Glens Falls Pediatric Consultants, PC
Pediatric Associates of Saratoga
Release of Information and HIPAA statement for a patient at least 18 Years of Age

_____ _____
Patient Name Date of Birth

I authorize the staff at Glens Falls Pediatrics Consultants and Pediatric Associates of Saratoga to release all office visit and health information regarding my care and treatment to the following person(s):

☐ Parents or Legal Guardians Only (names)

_____ Relationship to the patient _____,

_____ Relationship to the patient _____,

☐ I am at least 18 years of age and do **NOT** give permission for the staff at Glens Falls Pediatrics and Pediatric Associates of Saratoga to release information regarding my office visit and health information concerning my care and treatment to anyone.

How would you like us to communicate (please check all that apply)

Appointment Information			**Medical Information**		
On home phone	☐	#_____	On home phone	☐	#_____
On cell phone	☐	#_____	On cell phone	☐	#_____
Cell phone text	☐	#_____	Cell phone text	☐	#_____
With family member	☐	#_____	With family member	☐	#_____
Via email	☐	_____	Via email	☐	_____

This consent shall remain in effect until revoked in writing.

_____ _____
Patient Signature Date

Please provide a contact phone number for yourself as a patient: _____

_____ _____
Witness Date